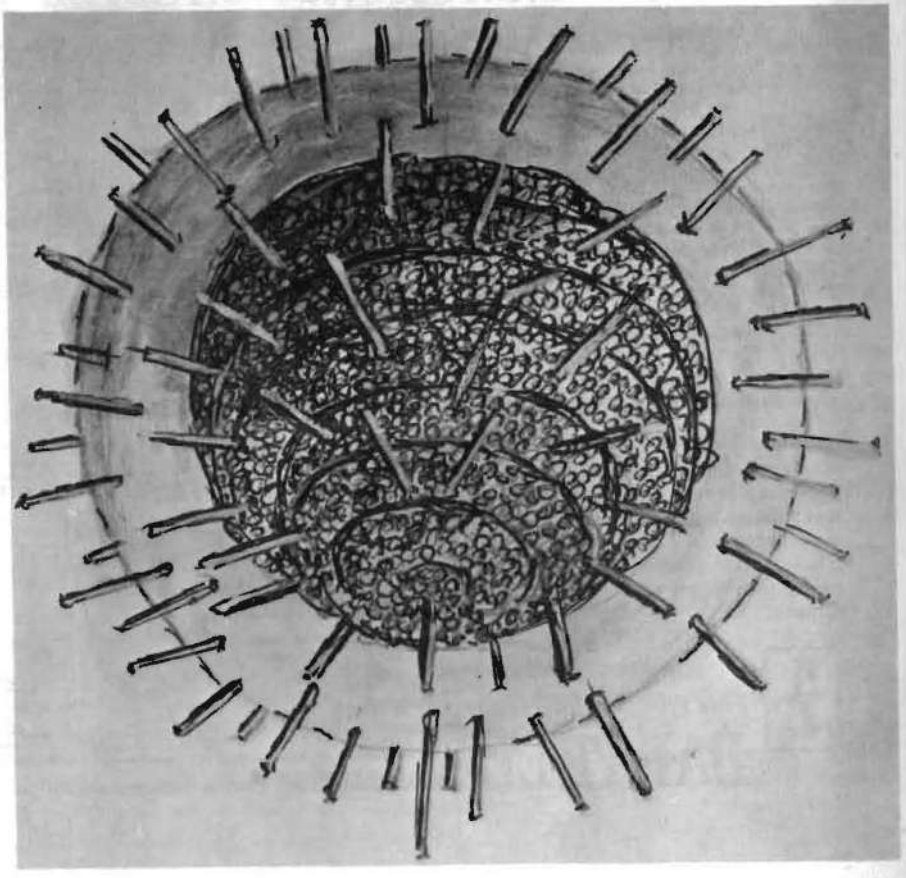
CALIFORNIA CHIROPRACTIC COLLEGES

LOS ANGELES COLLEGE OF CHIROPRACTIC

The Chirogram

THE CHIROPRACTIC PHYSICIAN OCTOBER 1976, VOL. 43, NO. 10



THE SWINE FLU VIRUS
SHOWN BY ELECTRON MICROSCOPY

(See story on page 6)

THE PRICE OF LEADERSHIP

Our Founder . . . .

ROYAL LEE, D.D.S.

Vitamin Products Company founded by Dr. Royal Lee, has gladly paid this price of Leadership for the past 40 years.

The passing of Dr. Lee (as much as he is missed) has not impaired our Leadership in the Nutritional Field. Mrs. Lee, with the assistance of company executives, adequately trained by Dr. Lee, is continuing to follow in his footsteps.

The proof that the original processing of our Nutritional Concentrates was the right method is attested by the fact that we have never to this day changed our processing methods.

Products such as CARDIOPLUS, VASCULIN, BETACOL and many more of the 120 items developed have received the highest tribute of Leadership by the attempts of competition to duplicate them. Some circulate stories that they have profited by our research. These claims, of course, are ridiculous since we have never divulged the secrets of our processing to anyone.

Our concern for your patient is only exceeded by the concern for the integrity of our products.

STANDARD PROCESS LABORATORIES, Inc.

Division of
Vitamin Products Company,
2023 W. Wisconsin Avenue,
Milwaukee, Wisconsin 53201

EDITORIAL COMMENT

MMLXXVI

In a recent editorial, we wondered what the next hundred years might bring. Here, Doctor, might be your typical day in 2076.

You are due in your office at 0800. Your office is in a large Health Complex where all branches of the health sciences combine efforts to keep people well, more so than treating illness.

You step into your Teleporter and arrive at the office in less than 5 minutes. The office is 120 miles away.

Your desk is equipped with a central panel and several viewing screens. You flip a switch marked "News" and the headlines appear on the screen - each with a code number. You indicate the stories that interest you, and they are displayed on the screens, both in print, and with narration and motion pictures.

Next you press the button marked "Communication" (Mail service disappeared late in the 20th Century, and was replaced by microwave link-up). Your messages flow across the screen, and at the end of each message, you press "SEND" and dictate your reply, which is instantly transmitted to your correspondent. Next you slip your Identacard into a slot, and the Bankomputer deducts the amount of your monthly bills from your balance and credits it at your direction. We stopped using money years ago.

It's time to see patients. Cancer, Mental Illness and all of the other dread scourges are a matter of dismal history - they are no more. As each patient presents himself, you run a Scanner over his body, which relays all physical and mental factors to the computerized analyzer, which gives you a read-out on the patients condition, warning of possible illnesses that may be approaching. You treat accordingly.

When the last patient has been seen, you activate another screen; touch time, date and location buttons, and spend an hour watching the lives of a family in Atlantis. The lost continent was finally found, with the help of instrumentation that can recall past events in sight and sound, with forgotten languages translated to a modern, understandable language.

A glance at the calendar informs you that you have a conference tomorrow in Hong Kong; you must pick up a new Energy Capsule; and that an old classmate passed away and was disintegrated. You must remember to contribute to a memorial plaque. Now to teleport home.

Your mate (marriage has long since disappeared) meets you at the entryport. "Dear", she says, "you look tired. Why don't we flash over to Paris and have a good meal. We can get back and get to bed early." You wearily agree. You have had a hard day.

If the above seems a fantasy, turn back a century to 1876 and make a comparison. Besides, if our predictions have not happened by 2076, we'll gladly retract our story, with apologies. JDK

THE CHIROGRAM • JOURNAL
OF THE LOS ANGELES COLLEGE OF CHIROPRACTIC

CIRCULATION — 11,000

THE CHIROPRACTIC PHYSICIAN OCTOBER 1976, VOL. 43, NO. 10

Dedicated to the dissemination of current and research information relative to the field of Chiropractic Therapeutics

FEATURE ARTICLES

REGULAR FEATURES

THE CHIROGRAM is published monthly by the Los Angeles College of Chiropractic, 920 E. Broadway, Glendale, California 91205
ADVERTISING DEADLINE: All new display copy must be in our hands by the first of the month preceding publication. Classified ads must be in our hands 6 weeks prior to publication, accompanied by check. Make checks payable to THE CHIROGRAM, 920 E. Broadway, Glendale, CA 91205. Currency mailed at sender's risk. All contracts are subject to approval by the editorial board. The right to reject any advertising is reserved. CHANGE OF ADDRESS: Allow 4 weeks for change of address to become effective. Give both old and new addresses, including zip codes. SUBSCRIPTION: $5 per year, 50 cents for single copy and for back issues when available, payment in advance. THE CHIROGRAM does not accept responsibility for opinions expressed in advertisements or signed articles. No portion of this publication may be reproduced without written permission.

THE VIRAL AGENT OF SWINE INFLUENZA

BY CHARLES LaDOCHY, Ph. D.
Department of Microbiology
Los Angeles College of Chiropractic

In the last two weeks of January 1976, the State of New Jersey was experiencing widespread outbreaks of influenza in the military and civilian populations. In Fort Dix, New Jersey, twenty-two recruits, who were recovering from flu, had antibodies to A/ swine virus and a history of contact with swine was identified. One of these latter virus strains was from an 18-year-old recruit who died. Post-mortem findings were consistent with pulmonary viral infection. The neuraminidase of the New Jersey isolates was also shown to be similar to that of swine influenza A-virus.

This year scattered outbreaks and sporadic influenza-like illnesses have been reported from Mississippi, Arkansas, and Washington, D.C. In May, outbreaks of influenza A have been reported from Malaysia and South Africa. Currently an epidemic is in Santiago, Chile, caused by the A/Victoria virus. This is the most widespread outbreak since the 1968-69 Hong Kong episode. Isolates of influenza A from the Sao Paulo, Brazil outbreak have been confirmed as A/Victoria/3/75-like. The same virus outbreak also has been reported from French Guiana, Martinique, Argentina, and Singapore.

Antibodies to the swine influenza virus are found in many persons in the United States over the age of 50, suggesting that antigenically similar viruses were widespread in the human population. There is some evidence from antibody prevalence studies that occasional infections with swine influenza virus may have occurred in most recent years among persons in frequent contact with swine.

The U.S. Government decided to sponsor a nationwide innoculation against the swine influenza virus.

Why do we call this virus infection "swine influenza"?

In 1918 millions of pigs contracted this disease and thousands died of it. It now occurs annually. Swine influenza is actually human influenza A, the influenza that was so widely prevalent in man, recognized by Richard Shope, Rockefeller Institute, Princeton, and which virus adapted itself to a new host. It has demonstrated two curious factors in the disease: 1. the typical symptoms are not produced by the virus only but by a combination of the virus and a common bacillus, also virtually harmless alone. 2. The agent has a complex life cycle involving the lungworm, a parasite of the swine respiratory tract, which in turn has an intermediate host in the earthworm which is eaten by the pigs that are permitted to root around in the soil. The still-to-be-answered question, of course, is

where human influenza goes when it is not epidemic, and Shope's findings raise the question of whether or not swine might be a natural *reservoir* for the disease.

Dr. Edwin D. Kilbourne, at Mt. Sinai School of Medicine in New York, N.Y. and also Dr. Robert Webster of St. Jude's Childrens Research Hospital in Memphis, Tennessee declared in 1973 that evidences point strongly to the animal theory.

The influenza virus belongs to the order of Myxoviruses. It is so called because of its affinity for mucous/myxo/substances on the surfaces of the cells they infect. They multiply in the surface cells of the respiratory tract, resulting in the all-too-familiar mucous discharge from these areas.

A very high level of antibodies must be present in the blood to spill over into this peripheral tissue so that repeated immunizations might well be required.

The structure of the virus *(See illustration)* shows a coiled body of RNA in the core covered with a lipoprotein envelope, spherical in shape, diameter 1000 Angstrom. Through this envelope protrudes an array of stubby protein spikes. The tips of the spikes, which make contact with the cell surface prior to in-infection, are believed to contain the *neuraminidase.* This enzyme eats away part of the cell surface and presumably is part of the virus' equipment for gaining entry into the host cell.

The virus agglutinates red blood corpuscles, but after a short period of time, the red blood corpuscles spontaneously separate again and then, for a period of time, are resistant to viral agglutination.

Serologic diagnosis of influenza is most readily made by the hemagglutination-inhibition (HI) or by the complement fixation (CF) tests.

The name "influenza" derives from the Italian word "influenza," meaning influence, or "influenza di freddo" (cold), being epidemic mostly in winter time. The "grande influenza" was an epidemic in 1357 in Europe. In 1743 a serious outbreak occurred in England. The 1918-19 epidemic of "Spanish influenza" was the worst of the great plagues of history. In October, 1918, 400,000 Americans died of flu, or its sequelae, and the following winter 500 million persons of the world contracted the disease, and twenty-one million died of it. The panglobal epidemic of "Asian flu" of 1957-58 was equally virulent, but by that time antibiotics had been developed to control the bacterial pneumonia that so often followed in its wake, and so, although morbidity was high in the United States, of the 70,000 fatalities occuring, only the old, infirm and the very young died.

The influenza "problem" is its remarkably fast mutability. Antibodies against last year's influenza are hopelessly out of date by the next year.

That was the reason that the national vaccine program was scheduled this fall in the hope of preventing a possible epidemic of swine influenza during the cold days of the winter months.

The Congress has appropriated 135 million dollars to finance the vaccine production of the National Influenza Immunization Program. Data of field trials conducted during the summer of 1976 were analysed at an Influenza Workshop held in Bethesda, Maryland on June 21, 1976.

Field trials from four U.S. influenza vaccine producers involved more than 5,200 adults and children. Trials were double-blind with placebo controls, and used comparable protocols and analytical methods.

The following vaccines were used in the field trials: 1. Monovalent preparations of swine influenza virus/Hsw 1N1/, 2. Bivalent preparations including both swine influenza virus and A/Victoria/75/H3N2/, and 3. Monovalent B virus preparations containing B/Hong Kong/72.

All manufacturers used standard procedures to purify, concentrate, and inactivate the virus.

Preliminary analysis of field trial data provides the following general conclusions:

1. Approximately 90% of the vaccinees 25 years of age or older responded well to even the lowest adult dose 200 CCA units of monovalent swine influenza vaccines. Side effects, of low-grade fever, malaise, and myalgia among the adult volunteers were most frequent with the highest test dose 800 CCA units of whole-virus vaccines.

2. Children 3-10 years old had less favorable immune responses to the swine influenza vaccines than did adults.

3. Young adults ages 18-24 had less favorable antibody responses to the swine influenza vaccines than did older adults.

4. Bivalent A vaccines containing both swine influenza virus and A/Victoria/75 virus, either whole or split, at 200 CCA or 400 CCA units of each component antigen, were about equally immunogenic in persons 25 years of age or older. They were less effective in younger persons.

5. Monovalent B/Hong Kong/72 vaccines containing 500 CCA units of antigen produced good antibody responses in nearly all adult vaccinees tested.

6. Vaccines administered by needle syringe and by jet injector produced comparable rates of seroconversion and levels of antibody responses.

The government sponsored studies claim that results of the recent field trials provide clear evidence that adults of approximately 25 years of age or older can safely and effectively be immunized against A/New Jersey/Influenza with a single dose of vaccine. Furthermore the trials indicate that younger adults and children as young as 3 years old can also be safely immunized but that additional data will be needed.

PRECAUTIONS:

Certain precautions should be observed. Before being vaccinated persons known to be hypersensitive to egg protein should be given

a skin test or other allergy-evaluating test using the swine influenza vaccine as antigen.

SIDE EFFECTS:

Fever, malaise, myalgia and other systemic symptoms of toxicity occurring 6-12 hours after vaccination and persisting 1-2 days. Such effects occur most frequently in children. Allergic responses are exceedingly uncommon. Current influenza vaccines contain only a minute quantity of egg protein, they do on rare occasions, provoke hypersensitivity reactions.

Neurologic disorders, like encephalopathy, are rare. Medical literature revealed only about a dozen such reports since 1950. Full recovery was almost always reported.

The effect of swine influenza in pregnancy cannot be forecast with assurance. Physicians generally avoid prescribing unnecessary drugs and biotics for pregnant women, especially in the first trimester.

In summary influenza vaccine has only rarely, if ever, been associated with severe adverse reactions or permanent disability. It is considered to be safe and quite suitable for wide-scale community use.

The World Health Organization reports in *The Weekly Epidemiologic Record* 51 (28,29): 227, 233-234, 1976: Widespread outbreaks of influenza have been reported from Australia, New Zealand, and South Africa since early June with peak activities in mid-July. Many isolates of A/Victoria virus have been made. A/Victoria isolates also have been reported from Argentina, Austria, Czechoslovakia, Denmark, the Netherlands, Portugal, Singapore, Spain, Germany, Belgium, France, Morocco, Kenya, Senegal, and Uruguay. Isolates of A/England from Greece, Germany, Belgium, France, Morocco, Sri Lanka, and India and A/Port Chalmers from Poland, Kenya, Senegal, and Sri Lanka have been reported.

THE MOTOR SYSTEM: A GENERAL LOOK AT ITS COMPONENTS AND THEIR CLINICAL CORRELATIONS

By Tuan A. Tran, Ph. D. and Laura M. Christiansen
LACC Department of Anatomy

Introduction:

Skeletal muscle activity is ultimately mediated by impulses conducted over motor neurons in the anterior cell column of the spinal cord and in motor nuclei of cranial nerves. Fundamental to the motor system and, indeed to the nervous system as a whole, is the concept of the "final common path" or a lower motor neuron. However, as the name "final common path" implies, motor activity does not originate in motor neurons. Voluntary muscle action is initiated and regulated by higher centers. Reflex muscle action occurs in response to the myriad of sensory information delivered to the Central Nervous System, but it may be modulated by higher centers also. Thus, the excitatory state of each motor neuron depends on the summation of all facilitory and inhibitory impulses conducted over hundreds of neurons originating at all levels of the Central Nervous System and converging on the "final common path".

There exists a hierarchy of muscle control centers that have developed one after the other in the course of evolution. As each new (higher) center has evolved, it has superceded the older (lower) centers, permitting a higher degree of muscular versatility. The lower centers lose their dominance but their neurons are frequently taken over and utilized by higher centers for the conduction of impulses to the "final common path". Neuronal influences on the "final common path" are listed below, according to their ascending level of motor control.

1. Reflex arc (simple and local, and widespread and intersegmental).
2. Reticular system (operative at several levels, including the red nucleus).
3. Vestibular system (including antigravity and acceleration controls).
4. Medial longitudinal fasciculus (M.L.F.), tectobulbar and tectospinal tracts.
5. Extrapyramidal system.
6. Cerebellum (massive but comparatively straight forward in function).
7. Pyramidal system.

Several of these motor controls have been shown in detail in relation to sensory systems with which they are intimately associated. It is noteworthy to indicate that motor activity may be mediated by spinal reflex arcs (segmental and intersegmental) in

response to painful, tactile, thermal, and proprioceptive stimuli. It is of importance to recall that various reflex activities in the brain stem are mediated by reticular neurons and that the excitatory state of motor neurons in the entire neuroaxis is influenced by reticular inhibitory and facilitory centers. The vestibular system through the lateral and medial (fibers within the M.L.F.) vestibulospinal tracts was observed to illicit reflex skeletal muscle activity that brings about postural adjustments in response to gravitational forces, as well as coordinated movements of the neck and eyes in response to forces of acceleration or rotation. Of interest also is that impulses originating in the audiovisual centers in the midbrain tectum and travelling over fibers in the medial longitudinal fasciculus, and in tectobulbar and tectospinal tracts mediate complex gross reflex movements in reaction to sudden, unexpected, auditory or visual stimuli. It should be remembered, also, that impulses mediating vestibular, auditory, and visual reflex activity may be relayed to motor neurons by reticular nuclei and reticulobulbar and reticulospinal fibers.

The Pyramidal System:

The Pyramidal system is primarily concerned with fine, isolated, voluntary motor movements that form the basis for the acquisition of motor skills. It consists of all neurons that originate in the cerebral cortex and end directly, without relays or synapses, in the motor neuron pool. This includes the corticospinal and corticobulbar tracts. The neurons involved with the pyramidal system have been described as the gigantic pyramidal cells (Betz cells) located in the fifth layer of the motor cortex. Actually the fibers originate from widespread areas of the neocortex and, in fact, the Betz cells contribute only about 3 to 4% of the fibers found in the pyramidal system. Thirty per cent of the fibers arise from smaller pyramidal cells in the motor cortex, 10% from smaller pyramidal cells in the premotor cortex, 20% from pyramidals in the rest of the frontal lobe, 20% from the somesthetic area, and the remaining 20% from the rest of the neocortex.

In the cortex of the precentral gyrus (motor cortex) the parts of the body are arranged topographically. The head area is located at the inferior aspect of the precentral gyrus adjacent to the lateral fissure. Proceeding upward there are found in order, areas for the fingers, hand, forearm, elbow, arm, shoulder, trunk and hip. Areas for parts of the inferior extremity are found in the medial surface in the paracentral lobule. The size of the area for a group of muscles is directly related to the degree to which they control fine movements. For example, the area for muscles of the hand is large, whereas that for the muscles of the back is small. The location of the corticospinal tract within the central nervous system is quite distinct and provides many major anatomic landmarks and clinical correlations.

Corticobulbar (or cortico nuclear) fibers distribute to motor nuclei of cranial nerves. In contrast to muscles activated by corticospinal fibers, most muscles influenced by corticobulbar fibers have bilateral cortical representation, i.e., their motor neurons receive both homolateral (ipsilateral) and contralateral corticobulbar fibers. These include the muscles of mastication, muscles of the tongue, the

laryngeal and pharyngeal muscles, the extra-ocular muscles (except the superior oblique), and the muscles of the upper half of the face (muscles of the lower half of the face have contralateral representation only).

The Extrapyramidal System:

The extrapyramidal system is primarily concerned with the gross synergic movements of locomotion, expression and postural adjustment, together with the semiautomatic movements associated with voluntary activities such as swinging the arms when walking. It apparently operates by exerting inhibitory or facilitory influences on various other motor centers. The largest nuclear masses belonging to this system are the basal ganglia, which include the caudate nucleus, putamen and globus pallidus. Some authors include the amygdala and claustrum with the basal ganglia, though the former is most closely related functionally to the olfactory and limbic systems and the function of the latter is not clearly understood. The putamen and the globus pallidus form the lenticular nucleus. A second group of nuclei, located in the subthalamus and mesencephalon (midbrain), are also part of this system. The most important members of this group are the subthalamic nucleus, the zona incerta, the substantia nigra and the nucleus ruber (Red nucleus).

Afferent connections from the thalamus are logical phylogenetically since in lower animals, where the thalamus is the highest sensory correlation center, the extrapyramidal system is the highest motor control system. In higher mammals, where encephalization has taken place, the extrapyramidal system falls under cerebral dominance and afferants from the cortex to the extrapyramidal system would be expected.

Clinical Applications:

It was suggested that the extrapyramidal system functions as an inhibitor-excitor system. A number of pathologic conditions support this point of view. The neostriatum formed by the putamen and the caudate nucleus seems to be predominantly inhibitory. *Status marmoratus*, a disease of the neostriatum, results in athetosis, a slow uncontrolled writhing of the extremities, chiefly in the fingers and wrists. *Chorea*, characterized by sudden quick, jerky, involuntary, purposeless muscle movements, is also caused by damage to the neostriatum. *Sydenham's Chorea* occurs in children as a complication of rheumatic fever, but the damage is not permanent and the recovery is complete. *Huntington's Chorea* is an inherited disease which becomes progressively worse and since there are defects in the cerebral cortex as well as in the neostriatum, it leads to severe mental deterioration.

The palleostriatum or globus pallidus seems to be excitatory and it may well be the excitor mechanism released when the inhibitory neostriatum is damaged. The fact that removal or destruction of the globus pallidus may dramatically relieve the athetoid patient lends credence to this hypothesis.

Both the subthalamic nucleus and the substantia nigra appear to have inhibitory functions. A lesion of the subthalamic nucleus

causes *hemiballismus*, a disease which is characterized by continual wild, flail-like movements of one arm. Degeneration of the substantia nigra results in *Parkinson's disease*, characterized by muscular hypertonus, stiffness, but not paralysis of movement, and poverty of associated movements. In addition there is a characteristic "pill rolling" tremor at rest, and a fixed expression. The patient stands with head and shoulders stooped and walks with short, shuffling steps. There is difficulty in starting to take the first steps, but once underway the pace becomes more and more rapid, and the patient has difficulty stopping at the desired goal.

Clinical correlations of the Pyramidal System will appear in the coming issue.

WILL THE REAL FUNCTIONAL SHORT LEG PLEASE STEP FORWARD

For years, the so-called "short leg problem" has plagued the chiropractic profession. Many techniques have studied the problem. Some have based the effectiveness of the spinal adjustment upon the disappearance of the short leg. Few have ignored the problem. Most have given up on it.

Now, still another chiropractic physician steps forward with still another discovery about the vague and evasive short leg problem. Dr. Lowell E. Ward is the developer of the Precision Chiropractic Spinal Stress Methods and the author of "The Dynamics of Spinal Stress," "The Manual of Standard Chiropractic Procedures," and "The Manual of Standard Diagnostic Procedures."

Dr. Ward states, "the functional short leg problem is one of the most mis-understood phases of chiropractic practice as well as one of Chiropractic's most vital and exclusive practice advantages." He continues by relating that for many years he was "bugged" with the idea of the short leg and tried most every short leg technique

available in chiropractic. He felt that there must be an answer. However, most of the usual techniques did not produce consistency, nor was the percentage of results high enough to really settle on any one method.

Finally, after a harrowing, life-threatening experience with his young son, Dr. Ward accidentally discovered the key to really determining the short leg. "After years of taking various types and kinds of leg checks, I found there was one thing that we had inadvertently overlooked," claims Dr. Ward. "Actually, we had never flexed the legs in the prone position, heels to buttocks, holding at the buttocks for several seconds and then taking the leg check. Without this one maneuver, we have kept ourselves guessing and searching for answers, while the short leg problem remained a tantalizing mystery."

Ward states that once the heel to buttocks maneuver is made, the legs should be allowed to gently fall into their own relaxed, extended position. No corrections should be made in the distortion of the legs, ankle, or joints, and any deviations should remain as is in taking the leg checks.

Dr. Ward relates that the functional short leg is the foremost stressor producing the many bony and articular distortions and deformations of the lower extremities. Therefore, a leg check which even minutely corrects for any distortion or deformed joint position may grossly affect the accuracy of the leg check.

He feels that any leg check that does not utilize the heel to buttocks maneuver will not be an accurate one, nor will it be reliable enough to base other findings upon. Therefore, it should be objectively utilized with any system or technique the doctor chooses to employ. The functional short leg, as described by Dr. Ward, is created by many factors. Trauma is perhaps the foremost consideration. However, the trauma involved need not be confined to the pelvic area. It may, in fact be a trauma of any aspect of the spinal column. He believes that most any trauma will actually affect the balance of the entire spinal column. The imbalance is then passed on to the pelvis and creates unequal leg lengths or one leg being "pulled" shorter than the other and locked into the position of leg imbalance by musculo-ligamentous stress fixations. The functional short leg must be considered, according to Dr. Ward, as a by-product of spinal imbalance. Structural imbalance, once it sets up in spasms, contractions, and pathological contractures produces various kinds of degenerative processes such as myofascitis, deterioration and herniation of intervertebral disc, arthritis, etc.

Ward then asserts that at this point we have a choice. Shall we attack the functional short leg problem and ignore the spinal pathology creating it or shall we attack the spinal pathology and ignore its short leg sequelae? The latter choice will eventually solve both the paraspinal pathology problem and the functional short leg as well. So, he suggests that we do not need to make a choice that will limit chiropractic effectiveness. With the proper choice we can have it all.

"Perhaps the worst thing we can do in chiropractic practice is

reach in and correct, by way of adjustments, the functional short leg. To do this is to deny ourselves much of the healing processes of chiropractic. Learning to utilize the functional short leg," Ward continues, "is one of the greatest assets that we have in treating the total patient and his total neuro-skeletal disease process including many heretofore chiropractically irreversible pathological processes."

"The greatest incidence of chiropractic failure in degenerative disease, is that we stop short of adequate treatment. Our principle is powerful and accurate. It works if we will just find a way to give it the time with adequate corrective adjusting and counter-stressing challenge. If you know by experience that adjustments alone actually do wonders for patients, then I suggest that you see for yourself what can be done with 300,000 and 400,000 counter-stressing spinal adjustments with the treatment-a-step concept.

By utilizing the functional short leg for corrective purposes instead of correcting it, Dr. Ward claims that we can add the power of several hundred thousand counter-stressing adjustments in addition to doctor-administered spinal adjustments. "We've been settling for chiropractic's crumbs," reflects Dr. Ward, "instead of having the whole cake. We've had a form of chiropractic, but have denied ourselves chiropractic's real power. I challenge the fact that we've been correcting causes. I believe we've been more interested in relieving pain and discomfort than we have in correction."

"I feel we have now matured to the point that the magic of technique and quick relief of pain is not enough, it is not fulfilling. We, as a profession, are ready for proven, substantiated, and documentable chiropractic corrections. Utilizing the functional short leg, we temporarily fit the shoe lifts in such a style that the body at first accepts them as a balancing factor. Later, as the patient walks on the lift, the new balance challenges the area of neuro-musculo-skeletal imbalance pathology repeatedly.

"Gradually as the imbalance pathology is broken down and replaced with balance and regenerative tissue, the patient reacts to the shoe lift and the lift rejection process is thus initiated. When spinal balance and regeneration has reached its maximum point, most patients will be completely out of the lift. Only where major structural damage has taken place preventing restoration of musculo-skeletal balance or where there is an actual comparative anatomical short leg will the patient be required to have a permanent lift.

"Now, what have we done? We have achieved correction and regeneration and we have eliminated the functional short leg. We can have it all. Pre and post x-rays verify the success of the system."

The study of the functional short leg syndrome is as intriguing as anything in the chiropractic profession today. Use of the lifts should always be supervised by doctors who have been thoroughly trained in the new concept". Dr. Ward states, "I suppose some doctors will jump into this process of treatment unwisely and before they are adequately trained. However, I'm not worried about that, they will also probably drop it just as fast. I recommend thorough

and proper training so that doctors can learn to chart actual progress, communicating it to the patient, the insurance companies, etc. The concept of the use of the correct lift size is considerably more than the average chiropractor is accustomed to using. Without the proper lift size, the patient will tend to wear it much longer periods of time and will not reject it. Therefore, the lift is rendered non-counter-stressing in action."

Utilizing the functional short leg is a new chiropractic concept described in Dr. Ward's new book, "The Dynamics of Spinal Stress".

VALIUM SENDS MORE ADDICTS

By: Tracie Rozhon

Editor's Note: This would be a good article to reproduce and give to your patients, especially the women, many of whom seem to take them like candy.

Valium, that innocent-looking little round tranquilizer in the medicine cabinet is landing more abusers in hospital emergency rooms than any other drug in the United States, including heroin.

Not only are an increasing number of addicts using the drug, "but there's an awful lot of housewives in Timonium walking around like zombies," according to Charles Cox, Director of the Mayor's Office on Drug Abuse in Baltimore.

Among addicts, Valium is believed to "boost" a methadone high. According to Frank, an addict who has shot or sniffed everything from heroin to glue, methadone "blocks" most drugs.

"But with Valium," he said, "it's a nice high; a gentleman's - or a lady's - high."

Ellie, a 22-year-old "pill freak," agrees.

"You can just sit there and nod and watch cartoons - even though there's no TV set in the room," she laughingly explained.

Valium is perhaps most dangerous when mixed with alcohol - and that is where the middle-class husband or wife might get into trouble.

"The difficulty is that tranquilizers can be used unwittingly," Mr. Cox said, "and I'm not talking about the back streets."

"I'm talking about the housewife who has nervous tension and calls her friendly doctor and it's the first thing that pops into his mind, tatatata, Valium...she takes a pill, has a couple of martinis, and sets off in the family car with a buzz on."

Federal drug administrators and drug manufactures, who shy away from labeling Valium addictive, nevertheless agree it establishes a dependency.

According to the Physicians Desk Reference, the doctor's drug bible, Valium can produce withdrawal symptoms similar to those produced by barbituates and alcohol.

"Convulsions, tremor, abdominal and muscle cramps, vomiting and sweating" may result if the patient abruptly stops taking the pills, according to the drug digest.

"They use it to excess" explained Ernest Carabillo, Jr., head of the Federal Drug Enforcement Agency's project DAWN.

"You know, if one is good, two is better," he said. "The great American way."

In a survey of more than 800 hospital emergency rooms and 94,000 drug abuse incidents, the Drug Enforcement Agency found Valium the No. 1 drug of abuse.

It is also the most prescribed drug in the country, with wholesale sales totaling $132 million a year, according to the DEA's chief spokesman.

Most Valium is purchased in pharmacies by producing a prescription - just one way Valium abuse differs from heroin abuse.

"At first glance, it looks like most people get the drug on a legitimate prescription, so the source is different," Mr. Carabillo said.

Not only that, but many users come from a different demographic area: "There's an awful lot of middle-class women from the suburbs," he said.

According to the federal computer, nearly three-quarters of the abusers who land in emergency rooms are women and three-quarters are white.

The majority are 20 to 30 years old, and most are in the hospital because they overdosed.

And although the ties between the suburban housewife and the young addict might seem remote, they are not.

"I started on Valiums when my grandmother gave me one to sleep," said Sue, an addict being treated at the Man Alive drug program on Charles Street.

"Yeah, I remember my father was taking them for a back injury," Ellie said. "He joked about being 'lit like a June bug' so naturally, I had to try them."

There are different ways to get Valium, but the most obvious - and most legal - appears to be the most common.

Go to a doctor, any doctor. "When Vince (another Valium addict who is in one of the state mental hospitals) and I were taking them everyday, we'd go to a different doctor everyday," Frank said. "We never once had any trouble."

"Well, it's a very difficult position we're in," said a prominent Baltimore doctor who asked that his name not be used.

"Somebody comes in here and names a doctor, who they claim is their regular doctor, and they say he's on vacation and they need some Valium...

"So I write him a prescription - not for hundreds of pills - but maybe for 30," he continued. "I'm too busy to call and check with the other doctor...and I know there's some people who just go from doctor to doctor telling the same story."

"It's a real problem," he concluded.

Selling for 50 cents to $1 a pill, Valium is easy to find, especially around city methadone dispensing programs. At one center in Baltimore, a reporter witnessed six pill transactions in 30 minutes.

Within a few weeks, Valium, and its sister tranquilizer, Librium will be placed under federal control.

According to Drug Enforcement Administration spokesman, the change has been sought for years and formally was proposed by the Department of Health, Education and Welfare and the DEA August 15, 1973.

After over a year of study and a court challenge by Roche, the company that makes both Librium and Valium, the Food and Drug Administration just recommended the controls.

As yet unannounced, the new classification will mandate penalties - including a jail term - for illegal use and distribution of the drugs.

Despite their apparent victory in the fight against Valium abuse, critics now wonder if the controls will be stringent enough.

Placed in Schedule 4 along with some diet pills and tranquilizers, the illegal possession of Valium could result in a one year prison term and a $5,000 fine. In addition, the DEA would monitor the drug companies' manufacturing and distribution records. Pharmacists would keep reports on how much of the drug they sell.

"That sounds great," one city drug program director said. "But since most of the drug is sold by prescriptions, how are they going to know which are legitimate? And will cops go around busting people for taking tranquilizers?"

Ernest Carabillo, Jr., a DEA official, conceded the main purpose of the listing is not to obtain arrests.

"Hopefully, it will occur to the physician that this drug is not the safest, that it can be abused," he said.

"Unfortunately, the idea is now in the mind of the doctor that if a drug is not controlled, it is not dependence forming."

"This way, he'll warn patients about its danger or dispense it less," he concluded, adding that "of course, we'll never know whether he does - unless there's a decrease in the overall abuse of the drug."

Reprinted from THE ARKANSAS TRAVELER AND CHIROPRACTOR
September - October, 1975

FABLES, FACTS, AND FOODS

By Leonard D. Godwin, D. C.

Fourth in a Series

THE SUBJECT OF MIRACLES

There are some whom we might refer to as "miracle worshippers." They seem to need something out of the ordinary, some block-busting, thunderous violation of what we understand to be natural law. But for me there is a universe of "miracles" right before my face, even under my nose. Everyday I wake up to a universe teeming with miraculous if quite ordinary things.

Take the sun, for example. Our comprehension of the universe has revealed, however imperfectly it may ultimately turn out to be, enough of the ordinary, everyday facts about the sun and its rays that, if we pause and reflect upon them, they do indeed appear quite miraculous.

This tiny speck of dirt called earth swirling through the immensities of illimitable space, so say the Astronomers, receives only one millioneth of the sun's rays and energy. But without that all-important fraction of solar energy, life as we know it now could not exist on the planet earth.

Solar energy, travelling approximately 93 million earth miles to reach us, excites the minute chlorophyllic manufacturing "plants" in the cells of green, growing things. The activity within the green leaves (specifically the chloroplasts) enables the plant to synthesize (photosynthesis) inorganic (non-living) substances into plant "food." The plant uses this self-made food to feed itself, to grow, to bloom, to flower, and to reproduce. Now, here is a marvel, a miracle!

The animal, incapable of synthesizing inorganic materials into organic substances of its body, incorporates (eats, digests, assimilates) the plant food into its own body. The rabbit eats the green leaf and LO! the substance of the leaf is transformed at the cellular level into rabbit protein. Now that's a miracle!

We eat the rabbit protein and our bodies change it into human protein. Another miraculous transformation!

We take an acorn and plant it in the womb of Mother Earth. In time, it stirs in the warm darkness of its "womb", sprouts, becomes a seedling, a sapling, and finally an oak tree. No matter how many acorns we plant and eventually grow, they never grow up to become Elm trees or strawberry plants or wheat stalks. They always mature into oak trees. When you reflect on it, isn't that miraculous?

Some things, such as plant cellulose, are food for certain animals and non-food for other animals. Most plant cellulose, while beneficial as food-bulk, is not food substance for me and thee. It is not food for man because his body is not provided with the kind of enzymes necessary to render cellulose food for our tissues. Other life-forms do have such cellulose-digesting enzymes.

Certain bacteria can manufacture food out of petroleum; we can't. But we can take advantage of what the bacteria are capable of doing and eventually get a form of food from petroleum. We can, in a sense, eat oil (which is quite a miracle!), and some of us alive today may have to before this century ends.

THE CEREBROSPINAL FLUID – Part 2

Arthur V. Nilsson, A. B., D. C.

Los Angeles College of Chiropractic

NOTE: THERE ARE NO LYMPH CAPILLARIES IN THE BRAIN and SPINAL CORD.

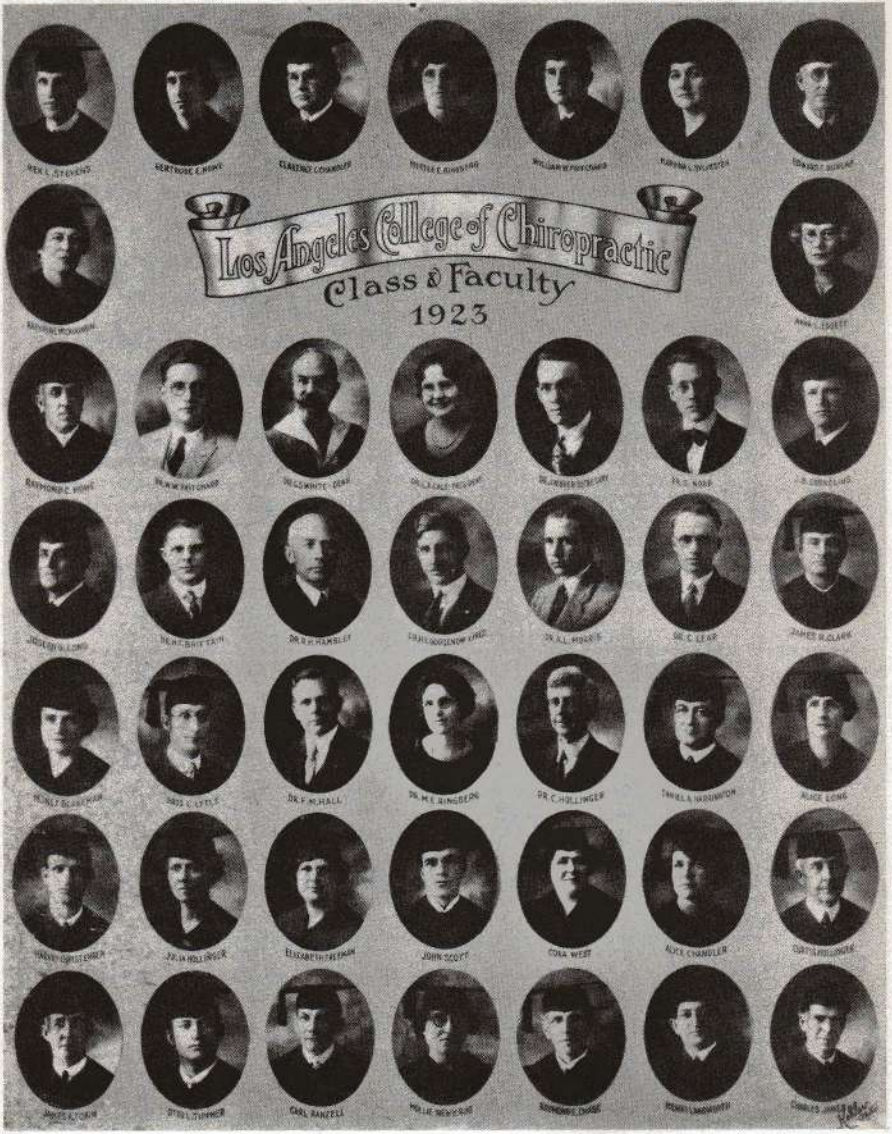
The cerebrospinal fluid is clear and slightly alkaline with a specific gravity of approximately 1007. It contains inorganic salts in solution similar to those in the blood plasma and there are some traces of protein and glucose. The cerebrospinal fluid is secreted into the ventricles of the brain. This fluid travels through the median aperture and the foramina of the lateral recesses of the fourth ventricle, thus entering the subarachnoid space in the cerebello-medullary and pontine cisterns. Within the cranium the cerebrospinal fluid passes upward through the roof in the tentorium cerebelli and then forwards and laterally over the inferior surface of the cerebrum. Finally it rises over the lateral aspect of each hemisphere to reach the arachnoid villi and thus is able to pass back again into the blood stream.

There is no active flow within the vertebral canal but the process of diffusion and alterations of posture serve to maintain the character of the fluid constant throughout the entire extent of the sub-arachnoid space. Experimental work suggests that the spinal cerebrospinal fluid may drain back locally into the venous system through the vertebral venous plexuses, the intervertebral veins and the posterior intercostal and upper lumbar veins into the azygos and hemiazygos veins. The cerebrospinal fluid supports the brain and maintains a uniform pressure upon it. It has been stated that the brain weighing 1500 gm. in air weighs no more than 50 gm. in cerebrospinal fluid and through the latter the total weight of the system is evenly distributed to the meningeal parieties and their mechanical supports.

What is generally known of the circulation of the cerebrospinal fluid and of the arachnoid villi, has to a large extent been based on the findings of L. H. Weed and his collaborators.

Bibliography: "Gray's Anatomy", 35th British Edition.

NOTE: Second row from top, second graduate from left is Dr. A. V. Nilsson.


Los Angeles College of Chiropractic
Class & Faculty
1923

DR. DUANE SMITH, FIRST PRESIDENT OF CCA, DIES AT 76

Dr. Duane Smith, first president of the California Chiropractic Association died recently at the age of 76. He was buried at Rose Hills Memorial Park in Whittier, California.

A Certified Roentgenologist who maintained chiropractic practice in Huntington Park, Dr. Smith was a lifetime member of the CCA. He served as the association's first president in 1943-44, following the reorganization of the CCA in its present form.

He graduated from the Los Angeles College of Chiropractic in 1936 and completed the post-graduate course in X-ray Diagnosis in the LACC Graduate School.

He was a California licensed Clinical Laboratory Bioanalyst, and a member of the Examining Board of the American Board of Chiropractic Roentgenologists for 9 years.

He has been an Instructor in X-ray Diagnosis in the LACC Graduate School since 1948 and has lectured widely in the United States and in Canada.

Dr. F. Maynard Lipe, Dean of the Graduate School said, "X-ray has lost one of its pioneer Instructors. Duane Smith will be hard to replace. He will be sorely missed."

In Memoriam

Dr. Stella E. Allen
Edmond, Arkansas
†
Dr. Alta E. Pellerin
Van Nuys, California
†
Dr. Jacob J. Baerg
Paradise, California
†
Dr. Herman S. Schwartz
New Hyde Park, New York

1976

LICENSE RENEWAL SEMINAR CALENDAR

THE CALIFORNIA STATE BOARD OF CHIROPRACTIC EXAMINERS APPROVES SEMINARS, REGARDLESS OF BY WHOM PRESENTED, ON AN INDIVIDUAL SEMINAR BASIS. THE FOLLOWING SEMINARS ARE SCHEDULED BY LACC, FOR WHICH APPROVAL WILL BE SOUGHT.

Times:
Saturdays - 1:00 to 9:00 P.M.
Sundays - 9:00 A.M. to 4:00 P.M.

AT LACC GLENDALE	OFF CAMPUS: HOTELS
Fees: Preregistration $35 At the door $40	Fees: Preregistration $40 At the door $50
DATES	DATES and PLACES
* Wed. - Thu. Oct. 13 - 14 Sat. - Sun. Dec. 11 - 12	San Jose Sat. - Sun. Nov. 20 - 21

*SCHEDULED ON WEDNESDAY-THURSDAY FOR THE CONVENIENCE OF THOSE WHO FIND WEEK-END SEMINARS INCONVENIENT.

[SUBJECT]

THE PELVIS, THE LOWER EXTREMITIES AND THE RELATED VISCERA

Tear out this handy coupon NOW
and reserve your place
on the dates and location of your choice.
Enclose your check, and mail to:
L A C C, 920 E. Broadway, Glendale, CA 91205

Name _____ License No. _____

Street address _____

City _____ State _____ Zip _____

Please reserve my place in _____
CITY

On this week-end (or mid-week) dates _____

My check enclosed for $ _____ Signed: _____

If you require certification to a state other than California, please check here [ ]

LOS ANGELES COLLEGE OF CHIROPRACTIC GRADUATE SCHOOL

Contact: F. Maynard Lipe, D.C., Dean
920 E. Broadway, Glendale, CA 91205

X-RAY

Following ACA American College of Chiropractic Roentgenology Syllabus. Minimum 300 class hours with approximately 4500+ clinical practice course. Open to licentiates only.

ORTHOPEDICS

300 hours, following syllabus approved by the American Board of Chiropractic Orthopedists. Prepares for certification examination by the Board. New classes begin March, 1977. Closed after 3rd session.

DIAGNOSIS AND INTERNAL DISORDERS

330+ hours leading to Certification Program. Open.

DIVERSIFIED TECHNIC AND REFLEX COURSE

Manipulative methods for all joints, all systems. Dr. Roy Logan conducts lecture, demonstration and workshop. Personal attention to each participant.

GLENDALE, CALIFORNIA — LACC CAMPUS

1st WEEKEND ..... DIVERSIFIED TECHNIC
2nd WEEKEND ..... ORTHOPEDICS
4th WEEKEND ..... X-RAY
For Glendale courses, contact Dr. Anna Reeves, 213-345-1766

SOUTH SAN FRANCISCO - ROYAL INN (AIRPORT)

2nd WEEKEND ..... DIAGNOSIS/INTERNIST
Contact Dr. Patricia Abbott, 415-934-4016

BOISE, IDAHO
1st WEEKEND ..... X-RAY
Contact Dr. Tom Allegrezzo, 208-342-1400

All classes meet Saturday 2 to 9 PM and Sunday 9 AM to 4 PM

classified advertising

RATES: Name, address, box number etc. to be counted as part of the advertisement.
BOX NUMBERS: 50 cents per insertion additional to cover handling and postage costs to forward replies.
COSTS: 25 cents per word. Minimum $2.50 for ads under 10 words. All standard type.
ALL ADS PAYABLE IN ADVANCE to THE CHIROGRAM at 920 East Broadway, Glendale CA 91205. Check or Money Order must accompany request for ad. No ad will be published without payment. For your safety, send only check or money order. Do not send cash!
DEADLINE: 6 weeks prior to publication date.
WE RESERVE the right to correct spelling and punctuation, or to refuse any advertisement.
THE CHIROGRAM nor the publisher accept responsibility as to advertiser's claims, goods or products. The presence of an ad in the Chirogram does not imply endorsement by either this publication nor by the publisher.
DO NOT CALL the Chirogram office relative to box numbers in ads. No information will be given.

OFFICES FOR SALE, RENT OR LEASE

COMPLETELY FURNISHED OFFICE. Eclectic Approach office available in prime location. Small amount of cash and good credit can qualify you. Send resume plus financial statement or credit references to be submitted to our banker to John H. Flynn, C.C., 406 N. San Mateo Drive, San Mateo, CA 94402.

ORANGE COUNTY - well equipped, modern, chiropractic office. Will sell building or lease. $60,000 gross. Box 5874, Orange, CA 92667.

FOR SALE: Practice in Redlands, CA. Physio-therapy equipped. For information write: R. A. Perry, D. C. 334 Brookside Ave., Redlands, CA 92373 or call after 7 PM. 714-793-6349.

OFFICES FOR RENT: Newport Beach, California. Office of 800 square feet. available. Good location. 714-673-5990 after 4:00.

PROFESSIONAL BUILDING 7000 sq. ft. immediate occupancy with newly formed Chiropractic Health Clinic. New Doctors or Doctors with established practice. Profit sharing with no money down, or rent space. Call (213) 378-2294 for more information.

OFFICES FOR SALE, RENT OR LEASE

MEDICAL SUITE - LA MESA. 800 sq. ft. A/C, off-street parking. $300/month. 714-462-5016

PRACTICE - 2½ days earns $35,000. X-Ray, all equipped, low down. Lynwood, (213) 631-1708.

EQUIPMENT FOR SALE

GONSTEAD CERVICAL CHAIR, $100. Nervo-scope $75.00. Royal 550 Electric Typewriter $100.00. All equipment like new. Wayne Fiscus, D. C., 950 Woodside Road, Redwood City, CA 94061. (415) 369-6446.

FOR SALE: X-RAY - Picker portable home or office - complete - $1100. (213) 839-1521.

FOR SALE: Cameron Heartometer, Burdick Sine-O-Tron, Record-O-Fone (needs repair). P. O. Box 600, Atascadero, Calif. 93422. (805) 466-2978.

COLONIC Machines, Accessories, Parts and service. The Dierker Company Post Office Box 24A56, Los Angeles, CA 90024. Phone (213) 478-4647.

YOU CAN LEASE a 200/100 X-ray, installed. $132.50 per month. Basic unit includes hangers, tanks, cassettes and basic darkroom equipment. Reconditioned. We also buy doctors equipment. (213) 769-3419 or Box 1103, Burbank, CA 91507.

SINCE MR. WEST'S PASSING the West "Thermopads" are sold and repaired by the Apex Medical Equipment Company, 4329 Dalton, Los Angeles, California. Telephone (213) 849-4486.

NEW AND USED X-RAY equipment and supplies. Complete service. One call does it all. PACIFIC X-RAY COMPANY, 711 W. 16th St., Long Beach, Calif. 213-437-0494.

FOR SALE: Large stock of reconditioned used X-ray machines and accessories. IMRAD, 4150 West Pico Boulevard, Los Angeles, CA 90046. (213) 731-7544.

NU MULTI THERAPY TABLE OF elegance. Latest design features developed after years of engineering and research. Extremely versatile. Traction on cervical, pelvic or ankle, controlled separately or simultaneously with counter traction either alternating or sustained. Is controllable from 0 to 200 pounds. With or without traction. Nunes Therapy Engineering and Equipment, 1123 Palm St., San Jose, California 95110.

PULSATHERM: High energy surging short wave. Lease or purchase. R. J. Lindquist Co., Manufacturers 2419 W. 9th St., Los Angeles, CA 90006.

OPPORTUNITIES

EXPERIENCED Calif. D.C. available for vacation relief, estates, emergencies. R. K. Hursh, D. C., Box 28096, San Jose, CA 95059. 408-297-3440 evenings. Resume upon request.

OPPORTUNITIES

DOCTOR TO SHARE growing practice. Expanding in volume and holistic approach to health care. Knowledge of Gonstead and Eclectic approach helpful to qualify. Prime location economically and climate in Northern California. Send resume with picture to:
John H. Flynn, D. C., 406 N. San Mateo

NEW ADDITION to my office. Orthopedic practice. Will accept associate - or train recent graduate. Could also use part time doctor. W. E. Blount, D. C. 1980 Beach St., Concord CA 94519. (415) 685-8223.

GROUP PRACTICE BEING FORMED. 8700 square feet in modern free-standing building with adequate parking. Want several self-starters, financially responsible and non-smokers. Location in Van Nuys near freeways. Write resume to BOX 3945, THE CHIROGRAM or telephone (213) 784-4288.

PHILIP H. LAWRENCE, D. C. now available for Calif. temporary situations. (L.A.C.C. 1950) 916-878-0772. Just sold Sacramento practice of 25 years.

WANT TO SHARE office part time - West of La Cienega - North of Pico. Phone (213) 652-8554.

POST GRADUATE COURSES. Free catalog. American College, Highland Heights, Kentucky. (606) 781-1000.

RETIRED CHIROPRACTOR available during vacations or absences from your office. Varied experience. Anywhere in California. Dr. Lucille Most, 24 Alexander Ave., Daly City, CA 94014.
(415) 584-7725.

VACATION RENTALS

RENT-A-RANCH, Silverwood Lake. New western cabin sleeps 6. Secluded. 3 acres. Fishing, skiing, hunting. Year around. $75/weekend, $150/week.
Charles C. Van Soye, 3800 Larkstone Dr. Orange, Calif. 92669.

MISC.: SERVICES, ETC.

OBESITY! Nation's No. 1 health problem. Nutritional weight reducing program that works. Safe - fast - easy. Results or money refunded. Full details.
Tom Wortham, D. C., 530 E. Oakey Ave. Las Vegas, Nev. 89104.

CHIROPRACTIC BUSINESS SERVICES
Professional narrative writing.
Anna Reaves, D. C.
18614 Sherman Way, Reseda, CA 91335.
(213) 345-1766.

COLONIC Repairs and Parts -- All makes machines. The Dierker Company, Post Office Box 24A56, Los Angeles, Calif. 90024. Phone (213) 478-4647.

POEMS WANTED
The CALIFORNIA SOCIETY OF POETS is compiling a book of poems. If you have written a poem and would like our selection committee to consider it for publication, send your poem and a self-addressed stamped envelope to
CALIFORNIA SOCIETY OF POETS
P.O. Box 7933
San Francisco, California 94020.

GET *FAST* ACTION
WITH A CHIROGRAM AD

Use this for your Classified Ad.

...write here

what you want to say. 25 cents per word. Telephone or street numbers count as words. Send check or money order to the Chirogram, 920 E. Broadway, Glendale, CA 91205. No ad accepted without payment in advance. For your protection, do not send cash.

A WORD ABOUT OUR PRODUCT LINE:

It's 57 products long.
And the formulation is uniquely ours.
Each one was formulated for chiropractic need.

For Example:

VM No. 9 for bone integrity.

Dual salts of calcium provide buffering action for optimum calcium uptake. Vitamin D to assure maximum placement, and a series of nutrients that guarantee optimal bone restructuring.

Niatherm, VM No. 37

For circulatory insufficiency. A nutritional vasodilator when depressed circulation slows neural regeneration.

Baldrian, VM No. 33

A natural botanical relaxant when irritation and muscle spasm minimize effective adjustment.

That's three, Doctor, and all the other 57 products have and always are adjunctive specifically to your basic therapy.

WE'RE IN BUSINESS TO HELP YOU MAKE PEOPLE WELL –
And we have 57 formulas to prove it.

VITAMINERALS INC.
GLENDALE, CALIFORNIA 91201

Distributor listing

NORTHERN CALIFORNIA

DONALD KLOCK
P. O. Box 388, Los Altos
(425) 948-5469

STAN ADAIR
5425 Rambler Way, Sacramento
(916) 332-5436

SOUTHERN CALIFORNIA

ROY MILLAR · PAUL BENES
ED GALLAGHER
1815 Flower St., Glendale
(213) 245-1164

JACK SPECK
9953 El Nopal, Box DD
Santee, Cal 92071
(714) 448-7888

CREATING A MEMORIAL

Today, many property owners make outright bequests to educational institutions to establish memorial funds for themselves or for other persons. In a day of uncertainty and rapid change, such a gift is a means of securing a measure of immortality.

For example, Mr. X. had devoted his life to agriculture and foodstuff. He could leave a substantial part of his estate outright to a college to help develop the department of nutrition. This project would carry Mr. X's name.

Mrs. Y. is a widow whose husband would have liked to do more for a college at the time of his death, but felt he should leave the bulk of his estate to Mrs. Y. To carry out her husband's wishes, Mrs. Y. has included an outright bequest in her will that will allow the college to establish a fund as a memorial to Mr. Y.

The Deferred Gifts Office of Los Angeles College of Chiropractic will welcome an opportunity to cooperate with you and your attorneys in planning a future gift to the College.

GIFTS TO LOS ANGELES COLLEGE OF CHIROPRACTIC ARE TAX DEDUCTIBLE

LOS ANGELES COLLEGE OF CHIROPRACTIC

920 East Broadway, Glendale, California 91205

10-76

THE CHIROGRAM
920 E. Broadway
Glendale, CA 91205
Return Address Requested

Non-Profit Org.
U. S. POSTAGE
PAID
Permit No. 1212
Glendale, Calif.